DEPARTMENT OF DEFENSE
NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Summary of Benefits

Traditional Choice® Indemnity Plan

Effective January 1, 2006

Plan Provisions	Traditional Choice Indemnity Benefits Plan Benefits*
Calendar Year Deductible	
★ Individual	$200
★ Family	$600 (3 times individual)
Out-of-Pocket Limit (the maximum amount you pay for your share of covered expenses in a calendar year. Copays, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)	
★ Individual	$3,000
★ Family	$9,000 (3 times individual)
Lifetime Maximum	Unlimited
Hospital Precertification Please see your Summary Plan Description (SPD) for details.	You must precertify any scheduled hospital stay. $500 penalty for failure to precertify (penalty waived if you are overseas)
Preventive Care	
★ Routine physical exam and immunizations (one per calendar year)	100%, no deductible
★ Well-child care and immunizations Birth to age 7. Please see your SPD for age and frequency schedule.	100%, no deductible
★ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no deductible
★ Routine Mammogram (one per calendar year for women age 35 and over)	100%, no deductible
★ Prostate screening exam (one per calendar year for men age 40 and over)	100%, no deductible
★ Routine eye exam (one per calendar year)	100%, no deductible
★ Prescription eyewear - lenses, frames and contacts (in addition to Vision One® Discount Program)	100% up to a $150 maximum benefit per person per calendar year
★ Routine hearing exam (one per calendar year)	100%, no deductible
★ Hearing aids ($1,000 lifetime maximum)	100%, no deductible
Physician Services	
★ Office visits for treatment of illness or injury	80% after deductible
★ Diagnostic lab and X-ray	80% after deductible
★ Maternity care office visits	80% after deductible
★ In-office surgery	100% of first $1,000, no deductible; then 80% after deductible
★ Physician hospital visits	80% after deductible
★ Anesthesia	80% after deductible
★ Allergy testing, serum and injections	80% after deductible
★ Specialists (office visits)	80% after deductible
★ Second surgical opinion	100%, no deductible
Hospital Services	
★ Inpatient hospital room and board and ancillary services	80% after deductible
★ Inpatient and outpatient surgery	80% after deductible
★ Outpatient services	80% after deductible
★ Pre-operative testing	80%, no deductible
★ Other hospital services	80% after deductible
Emergency Care	
★ Hospital emergency room	80% after deductible
★ Hospital emergency room for non-emergency care	50% after deductible
★ Ambulance	80% after deductible

** Coverage is subject to reasonable and customary charges.*

Summary of Benefits

Effective January 1, 2006

continued

Traditional Choice Indemnity Benefits

Plan Provisions	Plan Benefits*
Other Health Care	
★ Convalescent facility (up to 90 days per calendar year)	80% after deductible
★ Home health care (up to 90 visits per calendar year)	80% after deductible
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible
★ Hospice (inpatient and outpatient)	100%, no deductible
★ Independent lab and X-ray facilities	80% after deductible
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible
★ Durable medical equipment	80% after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	80% after deductible
★ Bariatric surgery	50% after deductible
Mental Health Care**	
★ Inpatient	80% after deductible; up to 60 days per calendar year; 60% thereafter
★ Outpatient (up to 45 visits per calendar year)	80% after deductible

** *Outpatient day maximums for mental health and substance abuse are not combined.*

Substance Abuse Treatment**	
★ Inpatient (up to 45 days per calendar year)	80% after deductible
★ Outpatient (up to 45 visits per calendar year)	80% after deductible

** *Outpatient day maximums for mental health and substance abuse are not combined.*

Prescription Drug Benefits	*Participating Pharmacies*	*Non-Participating Pharmacies*
Participating Retail Pharmacy Program (up to a 30-day supply purchased at a local participating pharmacy)		
★ Generic drugs	100% after $10 copay	Not covered
★ Formulary brand-name drugs	100% after $25 copay	Not covered
★ Non-formulary brand-name drugs	100% after $35 copay	Not covered
Prescriptions Purchased Overseas		
★ Generic drugs	Not applicable	100% after deductible
★ Brand-name drugs	Not applicable	80% after deductible
Mail-Order Service (up to a 90-day supply)		
★ Generic drugs	100% after $20 copay	
★ Formulary brand-name drugs	100% after $40 copay	
★ Non-formulary brand-name drugs	100% after $60 copay	

* *Coverage is subject to reasonable and customary charges.*

This chart displays only a general description of your benefits under the DOD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.

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